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Towards a Person-Centred Approach to Design for Personalisation

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Abstract

This chapter reflects on the political and ethical dimensions of personalisation through an analysis of the Person-Centred Approach (PCA) as found in psychotherapy practice and research, political conciliation and education. We propose that the PCA has the potential to inform ethical frameworks in participatory design, and can help facilitate critical reflection on approaches to personalisation in healthcare and technologically connected services.

A context is provided by ubiquitous computing visions of an Internet of Things, contrasted with the needs of mental health service users, and by recent calls for explicit reflection by design researchers on the ethical and political implications of their processes. The chapter discusses models of the person found in the mindsets of design research, and in the different modes of psychotherapy practice, and positions the PCA as a generative framework (after Sanders' map of design practice and research), and as holistic, rather than behavioural, cognitive or systemic. The Person-Centred Approach of Carl Rogers is then introduced through the six necessary and sufficient conditions for therapeutic change, and a discussion on the importance of non-directivity to the approach; this is followed by a short analysis of three participatory design research projects, in which some aspects of the PCA are evident. We then develop our proposal for a Person-Centred Approach to Design, following the four dimensions of *timescale*, *power relations*, *levels of participation*, and *reflection on practice* (after Vines et al 2012). Finally, we discuss issues with the use of similar terminology by other practices, and reiterate the critical differences between the Person-Centred Approach and most approaches to designing Personalisation. We hope that

the chapter will allow design researchers to recognise that there are different modes of practice within the healthcare professions, and within psychology, and that these can have a significant impact on research methodology, including the configuration of participants within projects.

Introduction: context of the methodological development

"The rise of personalisation, and the increasing accuracy of defaults that have been selected for us, have a serious downside; they make it ever more tempting to operate on automatic pilot, rather than to investigate and to choose on our own" (Sunstein 2015).

"…as brands increasingly look to understand individual consumer needs, we'll soon be enjoying products that increasingly reflect our own individuality….big data means companies will increasingly personalise products to consumers' needs and preferences without asking" (Brand Genetics 2015).

"When you do something for me that

I can and need to do for myself

You contribute to my fear and weakness" (Anon[1].)

At a recent conference dedicated to the development of ubiquitous computing systems, including many for healthcare applications, it became clear that personal accounts of users were seen as untrustworthy. Far preferable were the data that could be produced through environmental or on-body monitoring, which would reveal the user to themselves. Personalisation has become algorithmic, depending on the recognition of existing patterns to predict future behaviour. Such emphasis on past behaviour however, precludes change, and embodies directivity, whether through recommendation systems in retail (presented by the marketing profession as consumer 'choice'), or through interventions to match desired standards of health or other social behaviours (often referred to as 'nudge' psychology, for example in healthcare management) (Voyer 2015). Even when the individual desires the same outcomes (and signs up to them), directivity needs to be carefully considered lest it become instrumental, rather than principled (Grant 1990/2002)[2]. While the personalisation of healthcare and financial systems, among others, is made possible by learning algorithms collecting biological and behavioural data, there are concerns regarding the erosion of both autonomous informed action (Lanier 2010, Thaler and Sunstein 2008).

The quotations above point to popular representations of personalisation, and the gap between these and what people might really need. In answer to these concerns, we propose that the behavioural model is not the only option for personalisation, and that an alternative approach to designing for personalisation offers an ethical and reflective alternative. This chapter describes this Person Centred Approach, its relationship with emerging design practices, and the confusions in terminology that may occur, particularly in personalised healthcare, through the use of terminology that draws on the person-centred tradition but is not connected to its foundations in Rogers' Person Centred Approach (PCA). Rogers' PCA is distinct in many respects from other psychological modalities. It is humanistic in outlook and has its roots in phenomenological and existential philosophy and practice. He developed the approach from Non-Directive Therapy through Client-Centred Therapy to Person-Centred

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[1] These lines are taken from an anonymously authored poem commonly used in counselling training.

[2] Grant distinguished between instrumental and principled non-directivity (1990/2002). This is dicussed in more detail later in the chapter.

Therapy through the 1940s to 1960s, and then to the broader Person-Centred Approach, which influenced educational, sociological and political theory and practice from the 1970s onwards (Embleton-Tudor et al 2004). It emphasises trust in the individual to grow and develop given the right environment (Joseph and Worsley 2005), and stands in contrast to deficit approaches, which focus on need rather than human potential (Freeth 2007).

This chapter's proposition, that the PCA may provide an attitude-, rather than technique-led framework for ethically sound Design for Personalisation, is based on work the authors are doing as part of a multidisciplinary team at Nottingham Trent University, funded by the UK's Engineering and Physical Sciences Research Council. They are developing a Person-Centred methodology for design research in an Internet of Things enabled by emerging e-textile technologies (An Internet of Soft Things 2015). The project offers generative design techniques to participants from the Nottinghamshire Mind Network community, including mental health service users, volunteers, staff, and managers. In the workshops, participants are seen as 'co-researchers' and through collaborative making and designing, reflect on the potential of interactive textiles to impact on their wellbeing.

The multidisciplinary research team includes different mindsets towards expertise, and different expectations regarding the role of making within the research h process. For some team members, making is usually the outcome of a user-centred research process, while for others, making is a process of skills acquisition. In both these approaches to research, making is configured through expertise, either in the delivery of the prototype as solution, or in the teaching of new skills. In this project, however, we are developing a participatory methodology that gives expertise back to the participants. In this model, making offers an opportunity to experience autonomy, provided basic skills are supported as part of a non-judgmental environment (Glazzard et al 2015). We hope that through making, participants may experience first-hand the building blocks of future technologies, which otherwise have the potential to remove personal agency.

The project shares guidelines for a Person-Centred Approach (PCA) to participatory design with mental health communities. Reflecting on our experience as a multi-disciplinary team seeking to become more inter-disciplinary, it is clear that such guidelines concern not only the participants or users, but also ourselves as researchers from diverse academic cultures, and with different experiences and training in working with people. We can only evolve as a team through reflection on our own experiences on the project, so we run de-briefing discussions as soon as possible after the participatory workshops. From these we produce audio recordings or written notes that can become material for further analysis of our approach. We find this reflective approach to research responds to recent calls for a reassessment of the user/individual in the design process, as well as the configuration of the role of designer, for example in the work of Fuad-Luke (2009), and Bezaitis and Robinson (2011). It also echoes Light and Akama's (2014) call for attention to the ethical and political dimensions of power relations in the context of users. They ask: "What if we go further in looking at the relational aspects of designing participatively?" (2014 p.152). A CHI special interest group report (Vines et al 2012) called explicitly for reflection on the efficacy and the ethics of participatory work in HCI, and pointed to a need for researchers and designers to fully acknowledge the epistemological and ethical roots of their methods around four key themes: *timescale*; *power relations*; *levels of participation*; and *reflecting on practice*. We propose that these are themes the Person-Centred Approach can help to address through taking an holistic view of the person, and we explore these later in this chapter.

Understanding the person in design research through the PCA

Design and healthcare both draw on a range of philosophical models of the person. In figure 3

1, from Sanders' review of the variety of approaches to design research involving people as 'users' or 'participants', these are called 'mindsets'. In mental health services, they are referred to as 'modes' and include Psychodynamic, Behavioural, and Person-Centred practices (McLeod 2013). At the heart of each of these lies a model of the human being that has a significant impact on methodology and evaluation of outcomes: a cognitive psychologist's view of methodological rigour in research will differ fundamentally from that of a person-centred psychotherapist because of these different underlying models of the person.

Figure 1

Elizabeth Sanders (2008) evolving map of design practice and design research

Models of the person in mental health practice include the deficit model, the social (or systems) model, and the holistic model (Ladd and Churchill 2012, Tyrer and Steinberg 2009). The Person-Centred Approach (the PCA) works according to the holistic model, while a behavioural psychologist would work according to either the deficit or social model. Applied crudely, design methods have tended to operate according to a deficit model, in which problem solving is understood to be at the root of 'design thinking', although this approach has recently been subject to critique (Brandt et al 2012, Kimbell 2011)[3]. The process of problem identification and solution development in design nonetheless has parallels with the diagnosis – treatment – cure model. The starting point of the deficit model is the assumption that something is wrong or broken, and needs to be fixed - and it is clear what that 'something' is. In health practice this model seeks biological or behavioural remedies and is driven by the expert role, leaving the individual patient with no responsibility beyond following a programme of treatment and, by analogy, the consumer none beyond following the product instructions. In contrast, some design aligns with the PCA in its awareness of the wicked nature of its problems and the ways they may be organically intertwined with solutions (Poldma 2015).

The social or systems model starts from the premise that the person is part of a wider ecology, and that our environment has an impact on our experiences and behaviour. Service design can be seen as operating on a social model. This approach may be more or less Person-Centred, in that it involves power relationships and levels of instrumentality. For example, a service design project could be carried out with the aim of improving user experience for no reason other than that users deserve to have a voice. However, if the same piece of service design is commissioned by a stakeholder with a specific agenda, such as increasing sales, or changing behaviour for more desirable health outcomes, then the approach becomes instrumental, as the stakeholder with power decides what is best for the persons involved. The presentation of toolkits from the point of view of the time-constrained organisation, which provide techniques for 'persuading' participants to take part, can be guilty of this. For example, the Social Design Methods Menu (Kimbell and Julier 2012), is informed by design management and social sciences, and while it recognises that "tools have the potential to change who we are" (p7), the being of the researcher or professional designer is absent; the holistic view of the user (or 'customer', p2) is material to be understood by the researcher in the course of achieving the organisation's aims.

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[3] The design thinking agenda allows the process, and its artefacts and resulting products to be democratically contested by all involved (Binder at al 2011); the normative organisational models, whether business or national health service, that instigate such design activity, however, also need to be recognised in relation to the democratic agency of each participant.

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Sanders' map of design research in figure 1 is organised around two dimensions: the horizontal describes mindset, while the vertical differentiates between design-led and research-led practices. The research-led approach is well established, and includes applied psychology, anthropology, and sociology (2008, p.14). Design-led approaches involve making and prototyping, whether by the designer (critical design, on the left), or by participants (generative design, on the right); research-led approaches roughly equate to the research *for* design paradigm, while design-led approaches align more with research *through* design (Frayling 1993). The horizontal dimension of mindset is relevant for our discussion because it deals with aspects of expertise and power relationships. It is along the mindset axis that we can reflexively place the evolving terminology of the user that we propose here; the Person-Centred Approach constitutes a mindset positioned on the far right of this scheme, no matter whether methods are design- or research-led, and as such it may provide a framework for other researchers who have identified the importance of a grounded, reflexive sensitivity when using participatory tools and techniques (Brandt et al 2012, Munteanu et al 2015, Vines et al 2012, Vines et al 2013, Wallace et al 2013).

This chapter unpacks what 'the person' means according to the Person-Centred Approach, and how this might differ from the model of the person that informs some other approaches to design for personalisation. Readers from design disciplines may recognise in the PCA an approach to relational complexity that could be further explored through the lifeworlds of Hallnäs and Redström (2002), Latour's Actor Network Theory (2005), or emergent and performative perspectives (Wallis 2009), among others. Needless to say, this chapter cannot deal with all of these, and we hope that others will take up challenge to critique and develop the term 'person-centred' in relation to the people involved in design.

To fully explore the relationship between a Person-Centred Approach and more conventional approaches to 'persons' in design processes, it is appropriate now to consider in more detail the features of the Person-Centred Approach by sketching out its roots in psychotherapeutic practice.

A holistic model for Participatory Design: the Person-Centred Approach

Here, we introduce some details of Rogers' development of a person-centred approach to psychotherapy, to indicate how its principles have been generalised into the PCA and to identify how it underpins our development of a person centred approach to design. Carl Rogers (1902–1987) was an influential American psychologist, and one of the founders of the humanistic approach to psychology. In 1951 he presented his theory of personality and behaviour as the final chapter of *Client-Centred Therapy* (1951), marking a radical departure from prevalent medicalised thinking and the traditional power dynamics of psychotherapy. This shift from diagnosis and interpretation, to listening, and a willingness to be fully present without the apparent safety of expert status and a directive attitude, offered a focus no longer intent on problem solving, but on the development of a trusting relationship, facilitating the growth and development of the individual (Casemore 2006). Consequently, the focus of the process became the person rather than the pathology, or problem. Rogers hypothesised that the individual has within him- or her-self vast resources for self-understanding and self-directed behaviour, accessible through the provision of a climate of facilitative psychological attitudes (Rogers 1974, p.116).

Rogers (1957) stated that there are six conditions for therapeutic personality change. It is important to note that Rogers emphasised that each is necessary and that together, they are sufficient for change to occur. While these have been recognised and absorbed into the work of practitioners beyond the PCA, they are often reduced to three 'core' conditions (empathy, congruence and unconditional positive regard), both in wider therapeutic training and design research (cf Slovák et al 2015). It is however, the 'necessary and sufficient' nature

of the six conditions that constitutes the PCA, and that we are working to embed in our participatory design research. The six conditions are summarised below. As far as possible, we leave the original language of PCA as applied in therapeutic practice intact to show their origins in Rogers' decades of research and reflexive practice, out of which we build our development of an ethical approach to personalisation in design[4]:

1.   Psychological Contact: there is at least a minimal relationship in which two people are aware of each other and each makes some perceived difference in the experiential field of the other.

2.   Client Incongruence: one person – the client – is feeling vulnerable or anxious; this arises from a discrepancy between the actual 'felt' experience and the self-concept the individual holds of her/himself.

3.   Therapist Congruence: the other – the therapist – is integrated in the relationship; s/he is able to be genuine as her/his actual experience is accurately represented by her/his awareness of her/himself.

4.   Therapist Unconditional Positive Regard (UPR) for the client: there are no conditions for acceptance; there is a prizing of the person (Rogers acknowledges Dewey here); it is the opposite of a selective, evaluating attitude; it is a caring for the client as a separate person with her/his own feelings and experiences.

5.   Therapist Empathic Understanding of the client's internal frame of reference and communication of this back to the client: accurate empathy might provide clarity or disentanglement from distress, leading to a sense of movement or relaxation.

6.   Client Perception of the therapist's empathic understanding and UPR: the client feels accepted and understood.

Working therapeutically from a Person-Centred perspective requires the therapist to be highly attuned and responsive to the client's feelings (Brodley 1996), sensing 'accurately the feelings and personal meanings that the client is experiencing' (Rogers 1980, p.116). As part of his practice-led theory, Rogers (1961) developed a concept of a continuum of process, using recorded therapy sessions to inform a scale that might be identifiable by an investigator. At one end of the scale was a 'fixity and remoteness of experiencing…. (in which) the individual has little or no recognition of the ebb and flow of the feeling life within him. The ways in which he construes experience have been set by his past, and are rigidly unaffected by the actualities of the present' (Rogers 1961, p.132-3). At the other end of the scale 'New feelings are experienced with immediacy and richness of detail…there is a growing and continuing sense of acceptant ownership of these changing feelings, a basic trust in his own process' (Rogers 1961, p. 151). To relate this back to the Conditions described above, this process tracks the movement from incongruence to congruence.

The Person-Centred Approach was a further development, which took the theory beyond therapeutic practice, and described "a point of view, a philosophy, an approach to life, a way of being" (Rogers, 1980, p.xvii), which subsequently informed holistic approaches to groupwork in education (Rogers and Freiberg 1993) and mediation and conciliation (Ladd 2005). Embleton–Tudor et al proposed "the person-centred approach offers a

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[4] The 'therapist/ client' terminology is therefore preserved, underlying our extension of it by analogy to the relationship between design actions and clients/ users/ participants/ stakeholders.

comprehensive, coherent and holistic approach to human life and concerns" (2004, p.3) including "citizenship and the personal, local and global issues of justice, peace and conflict; the wider social systems of couples, groups, communities and organisations; and the environment" (Embleton–Tudor et al 2004, p.3).

Within the therapeutic relationship, the Person-Centred Approach is holistic in its valuing and appreciation of the whole person; in contrast with the medical model, the PCA is not deficit-based but works with what is available to us in the here and now. If Person-Centred Therapy seeks to empower the individual to change by creating an empathic, non-judgemental and genuine relationship with the therapist in which it is OK for the individual to be truly themselves, then the Person-Centred Approach reconfigures that relationship in the context of society. A Person Centred design approach to personalisation would therefore seek to critically examine the ways in which the user is empowered or disempowered; this would include a frank appraisal of any organisational agendas (or 'directivity') embodied within design systems and products, much as in practice theory, where objects are understood to partially constitute practices (Kimbell 2009). .

~~Non-directivity~~

Levitt asserts that "Non-directivity is the distinguishing feature" of the Person Centred Approach, arising from adherence to the six conditions, and it is the non-directive attitude which defines the approach as "revolutionary and anti-authoritarian" (2005, p.i). Any person-centred practice would understand the relationship to be an end in itself, in which the therapist has "no pre-determined and specific outcomes or intentions for the service user to achieve" (Murphy et al 2013, p.708). However, non-directivity is difficult as it asks the expert to put aside their own goals for the client; if we are trained to habitually diagnose and intervene, non-directivity can be the hardest aspect of the PCA to achieve (Brodley 2006). In many cases, work can be at once empathic and *instrumentally* non-directive. Instrumental non-directivity can be seen in the application of types of behaviour by the therapist to achieve a specific goal, "such as building rapport or frustrating the client" (Grant, 1990/2002, Murphy et al 2013, p.708). *Principled* non-directivity, in contrast, describes the ethical attitude of the therapist towards the client's ability and willingness to self-actualisation (Sanders 2006), which does not aim to solve the client's problems, but focuses solely on developing a "trusting relationship with the client, demonstrating an inherent faith in their capacity to self-direct and acknowledging the individual's right to autonomy" (Casemore 2006, p.6).It is principled non-directivity that we propose facilitates ethical personalisation in design research and practice, as opposed to instrumental non-directivity, which more easily fits into organisational agendas and can work to design out individuals' creativity and improvisation (Bezaitis and Robinson 2011, Wallis 2009).

Aspects of the Person-Centred Approach in design research

We propose that design, especially 'user-centred', 'human-centred' and participatory approaches, can use the six conditions of the PCA to reflect on its efforts to act ethically towards its beneficiaries. This may be most obviously applied where the designer or design researcher is in contact with users in a co-design situation, and there is a clear relationship to be defined, and managed with a duty of care to the participant. It can also find application in explicit reflexivity around 'personalisation', where some technical or political parameters must be set, in the end, by the designers of complex dynamic systems. Further, we see potential for its development in the area of designing for everyday agency, as found in Non-Intentional Design (Brandes 2008),and some definitions of Open (Kettley et al 2011) or Relational Design (Hollingsworth 2011), which draw on Bourriaud's theory of relational aesthetics (Bourriaud 1998) and which recognise the potential for designed systems and

objects to empower or disempower people (Kimbell 2009).

It is possible to point to aspects of the PCA in many design projects, particularly those that have a participatory mindset, and we briefly discuss three examples below, in which we highlight how some of the conditions are met. The provocation of this chapter is that to be truly Person-Centred, a design process would have to reflexively embody all six necessary and sufficient conditions, but this is open to further work and feedback[5]. These projects are cited as contemporary examples of best practice, and yet we know from *An Internet of Soft Things* that explicitly striving to enact all the conditions poses significant challenges (2015).

Democratising Technology. This project (Light 2011) aimed to inspire confident participation through design, in what Light and Akama call the "discourses and practices of shaping techno-science" (2014, p.153). It dealt with the invisible networks of information and communication enabled by technology that impact significantly on people's lives. In this work, Light and Akama are concerned with themes of politics, power structures, relational experience, ecologies and timescales of commitment. They reflect on the influence that design processes have, not only on the imagined user experience with an object, but on the lifeworlds of all participants. The fact that they shift the focus of attention from the object that is being designed to the relations and infrastructures that inform lived experience, especially of care, align this work with the person centred approach. The presence of this 'matter of concern' (after Latour 2005), and their focus on the ethics of care resonates particularly with the PCA's requirement for unconditional positive regard (UPR). For Light and Akama, care is not something 'done to' the person, but is rather an "a priori and primordial condition" (2014, p.158). Further, their stress on treating care as non-instrumental reflects the principled non-directivity that is an outcome of the six conditions for PCA:

"care is manifested as and in support of 'sustainable and flourishing relations' (after Puig de la Bellacasa 2012, p.198), distinct from caring for or being cared for, conditions which describe a directional, instrumental relation, suggestive of a premeditated agenda and even the promotion of inadvertent learned dependencies" (Light and Akama p.158).

Light and Akama also point to the political and ethical issues of participatory design when distributed and mobile networks of designed things may not be available to participant experience, or accessible to researcher analysis; this leads them to discuss as yet non-existent forms of ICT, as well as the timescale implications for responsible researchers. They point to approaches such as Transformation Design and HCI for Development projects[6], which seek to create capacity for autonomous change and improvement in communities. This is described as an 'awakening' of reflective process (after Sangiorgi), and as an ongoing, living transformation rather than an end in itself (2014, p.152). While this describes a community rather than an individual, such 'awakening' can be seen in terms of the client (community) moving from incongruence towards congruence (Rogers 1961).

Personhood and Person-focused design. Jayne Wallace has developed design-led techniques

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[5] In fact, this is also contested in counselling and psychotherapy; the PCA can be found used in integrative practice as just one tool, as a way of ensuring psychological contact, rather than as a complete framework.

[6] HCI4D is a growing field of activity at the intersections of Human-Computer Interaction and socioeconomic development, based on the recognition that technology is neither culturally-neutral, static nor deterministic.

for empathy with participants. Her work using design probes with dementia sufferers takes an embodied, relational approach, which is contrasted with 'conventional understandings of loss of self' (Wallace et al 2013). Wallace's accounts of her participatory practice communicate a sense of her personal connection with her participants, achieved through an empathic listening approach (Marshall et al 2014). The Personhood Project was based on a "deep engagement" between Wallace as design researcher, and a woman with mild dementia, and her husband. This emphasis on engagement echoes the first of the six conditions for the PCA, Psychological Contact, which must be in place before any other therapeutic activity can take place.

Wallace also responded to the sense that her role as a researcher might be more important than the experience of the couple: "the researcher had a sense that the couple felt that there was a pressure on the researcher's time and that they should be as productive during their time together as possible. The researcher could sense that a little more reflective time and space could enable Gillian to articulate what she wanted to say more easily" (Marshall et al, p.761). Wallace brought different materials (wet clay) into the space for the next session, allowing the pace of conversation and activity to shift, and facilitated a more holistic experience, rather than focusing solely on the cognitive. This meant silence became acceptable, and the couple were able to contemplate and simply be, rather than produce and do. This sensitivity to the needs of the couple echoes the listening attitude of the person-centred therapist, and their Empathic Understanding of the client's internal frame of reference. By facilitating change in the sessions, Wallace communicated this understanding back to the couple, and there was a resulting sense of relaxation.

TAC-TILE Sounds. Researchers on the TAC-TILE Sounds project were concerned with facilitating an empathic connection with the participating children, rather than relying on the experts in the stakeholder group (Chamberlain 2010). Because the children had complex special needs, new forms of engagement, other than the more usual questionnaires and surveys, had to be developed. Instead of pursuing a research-for-design agenda, the approach was to realise a selection of vibro-acoustic furniture design concepts and then work from the children's direct experience: "Only when the designers produced working physical prototypes could the research team interact with the users and develop any meaningful sense of understanding." They found that "the working prototypes acted as a bridge between themselves, the therapists and the children" (Chamberlain 2010, p.168). As a result of these communication difficulties, the project found itself embracing non-directivity, meaning 'tasks' became replaced with the children's own emergent means of communication with prototype artefacts; the children became accepted as the experts of their own experience, challenging the team to experience Unconditional Positive Regard for the 'user'. This example highlights the different forms that listening (and therefore UPR) can take; more used to verbal and linguistic forms of communication, the researchers used prototyping to support communication of design concepts with the children (as in Jones and Wallis' experiential approaches to ethical informed consent 2005). Further, in such situations, listening has to be enacted through the whole body rather than be a solely auditory experience (Caldwell 2005), which relies enormously on the first on the first of the six conditions – Psychological Contact[7]. It might seem that this project differs fundamentally from the others in this respect, but it serves to demonstrate the non-medical approach of

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[7] There is a substantial literature on Contact Skills and Pre-Therapy, which seek to put this in place, as none of the other conditions can be met without it – see for example Prouty (2008).

the PCA, which does not begin with a defined medical condition or lack. While research approaches in personalisation might more commonly talk about demographics, target markets and populations, the PCA challenges shared conditions or behaviours as a starting point, being more concerned with relationships and capabilities.

The examples above suggest that a Person-Centred Approach to participatory design would emphasise the reflexivity of the designer and the exploration of their relationship with the participant. It would demand critical thinking about the design process and the roles within it. . Consequently, the process of designing itself becomes ethical, being based on valuing the other as opposed to 'values' which can sometimes be perceived as a static characteristic of a person; and while outcomes must remain uncertain, risk is embraced together. A side-effect of this is that a person-centred approach to design means learning and self-discovery arise for both designer and participant.

In professional counselling practice, the Person-Centred practitioner is supported by a formalised structure of supervision. A more experienced counsellor facilitates explicit reflection sessions, in which the counsellor checks recent therapeutic encounters against the six conditions; this is a requirement for membership of professional accreditation by the UKCP and BACP (xxx), and is an integral part of professional development, ethical assurance, and care for the wellbeing of the practitioner as well as the client. Arguably, a Person-Centred design approach would build in a similar structure for explicit reflection; without this, design projects may be experiential (in the psychotherapy terminology), but not Person-Centred in the classic sense.

Towards a Person-Centred Approach to Design Research

Returning to the four key themes that organises the epistemological and ethical roots of design methods according to Vines et al (2012), *timescale, power relations*, *levels of participation*, and *reflecting on practice*, this section briefly outlines how a Person-Centred Approach to participatory design might provide an ethical yet flexible framework for working with diverse communities.

Timescale: The approach to timescale in a Person Centred Approach to Design is concerned to achieve the conditions for constructive change outlined above, rather than to arrive at the correct interpretation of needs and context. As we saw in the section above on power relations, interpretation is treated somewhat differently in the PCA compared to other research milieux. As became evident in Wallace's work, a concern for timescale is a function of the phenomenological character of the person-centred approach that is essential for empathic understanding to emerge. In a therapeutic setting, because the participant is in control of what is discussed and disclosed, this cannot be constrained, and so the PCA does not tend to sit well with solution focused therapies (Iveson 2002). Consequently it is hard to manage within a culture focused on efficiency (Murphy et al 2013). In addition, evaluation is related to timescale, as it is enacted moment-by-moment, during participation, rather being left until after the event (Marshall et al 2014); Jones and Wallis (2005) developed a framework of moment-moment evaluation in which it is the responsibility of the facilitator to be present to the experience of the other throughout the encounter. Other ethical methods for phenomenological reflection include Interpersonal Process Recall, in which the power of interpretation rests with the participant (Kagan 1980, Kettley et al 2015b). The timescale of analysis is also stretched, as Grounded Theory techniques are often used as part of the phenomenological approach to interpersonal meaning making (Rennie 2006).

Power relations

Respect for the autonomy of the individual is central to the Person-Centred Approach, which

emphasises the personal power of the individual in the therapeutic relationship. Wilkins refutes the notion of *em*powering another, citing Rogers (1977, p.289): "it is not that this approach gives power to the person; it never takes it away" (Wilkins 2010, p.18). A Person-Centred Approach to Design offers a phenomenological process in which the participant owns the meaning of their experience, while researchers reflect on their own contribution to the process and respect the participant's individuality. Therefore, just as in a therapeutic context there is no expert other than the patient, in a design context a person centred approach requires that the expertise of participants is recognised as equal to that of the researchers/ designers.

The BACP Ethical Framework includes a section on autonomy, defined as respect for the client's right to be self-governing, which requires counsellors to "engage in explicit contracting in advance of any commitment by the client" (BACP 2010, p.7). In the context of Design Research, this contracting process requires that the researcher makes clear that they are taking a Person-Centred Approach, what the implications of this are for the roles of researchers and participants and for their relationship with each other. For example, the researcher would not position themselves as an expert, but make a commitment to offering the participants an empathic, valuing environment. The participants will understand that it is their role to engage in a process aimed at capturing their experience, and that the research is not primarily goal or outcome oriented. As a pragmatic extension of this, informed consent should be seen as part of an ongoing process, which participants can review against their experience of the research as it develops, rather than as a yes/no checklist to be completed at the start of the process (Bond, 2004). Good practice would therefore be to check informed consent at regular intervals and to be open to dialogue about it, with the possibility of making adjustments for individuals in response to their concerns or preferences.

Levels of participation and control: Co-design has shown interest in the ladder typology of participation first suggested by Arnstein in 1969, and developed by Hart in working with children (Arnstein 1969, Bates et al 2011). For both Arnstien and Bates, the typology is made up of eight levels or rungs, from non-participation through tokenism, to citizen control at the top, the assumption being that "participation without redistribution of power is an empty and frustrating process for the powerless" (Arnstein 1969, p.216). Carroll called for a 'policing of participation', through just such a taxonomy of levels and types of participation and recognition of the different meanings of the word in different practices (cited in Vines et al 2013, p.429). However, the PCA differs from existing Co-design and Participatory Design approaches in its attitude to directivity. Openness and a willingness to revise research questions and design goals with participants are increasingly evident in participatory approaches, giving more autonomy to the participant in defining the matters of concern, but the goal often remains a single technological outcome to a given problem. A Person-Centred Approach to Design can also see multiple technological artefacts as a positive outcome, acknowledging the validity of practice-based evidence (as opposed to evidence-based practice). In formalising the stages of personal growth the PCA recognises that people may not be able to engage in the way researchers might implicitly value, especially at the start of a relational process (Rogers 1961), In this way, the PCA answers concerns about 'tokenism' (Arnstein 1969) and apparent lack of engagement in its listening attitude, which facilitates confidence and personal growth. Listening is in itself a giving of power, and is experienced as therapeutic when the necessary conditions continue over a period of time (Rogers 1957), whether in a participatory design group, or in a therapeutic encounter.

Reflecting on practice: One of the challenges of a commitment to the PCA is engagement with individuals and institutions who do not share the values and beliefs of the person centred values, for example those who prioritise expertise and authority or whose primary

objective is administrative and/or organisational. Mearns and Thorne (2000) used the term 'articulation' to describe a process of genuine dialogue, with others who do not share the values of the PCA.   Mearns described articulation in these terms:

"I am concerned to be as clear as possible about what I want and my limits, but I am equally concerned to find out as much detail about the needs and limits of the other. Most important is that I want to learn from the articulation process. There are many possibilities for learning: I may learn from the expertise of the other; I may learn about some of my own inadequacies; I may learn how better to communicate within the articulation process…The opposite of articulation would be to stick rigidly and defensively to what we want, with no learning resulting and achieve a result that will probably not be the most creative" (2006, p.134-5)

This suggests that the role of a Person Centred designer working as part of a team or within an organisation that doesn't share the values of PCA is to maintain an open and flexible attitude, to be self-aware and self-reflexive, and to be transparent with others about experience, assumptions and aspirations.

However, the authors' current work shows that where participatory design is being undertaken with mental health service users, designers may find that such individuals are more accustomed to self-reflection than other target groups. Service users are frequently asked to co-monitor their therapeutic process and sometimes their recovery, depending on the philosophical orientation or 'modality' of therapy. Some tools such as the Recovery Star are widespread and not particular to one modality, they can be applied in a number of different ways. Further, if the relationship is an equal one, in which all participants are co-researchers in a shared process, it follows that all should reflect explicitly on that process, including the academic design researchers, as roles become blurred. External to the therapy session, trainee counsellors are supported by a system of supervision at a ratio of one hour of supervised reflection to four hours of client contact[8], and we suggest this system is considered in the participatory design community, as the new relationships involved in a person centred approach imply at least self-reflection and possibly personal growth for the researchers.

In the authors' current research project, this is emerging as an important finding (Glazzard et al 2015, Kettley et al 2015a). A design research methodology is emerging in which debriefing sessions between workshop facilitators serve to support the team's shared development of the research themes, supporting individuals for whom difficult personal issues are brought to the surface and providing insight into the growth of the research team as a context for the growth of the participants.

The problem with language: when is 'person-centred' not Person-Centred?

Working in the Person-Centred mode is not necessarily straightforward. The PCA often faces political resistance[9] because it challenges embedded power relations and the status held as a result of perceived expertise, and champions subjective experience and evidence found in practice (as opposed to evidence-based practice as required by risk-averse audit cultures). It also faces issues as a result of the misappropriation of 'person-centred' as terminology, which is found conflated with 'patient-centred', 'positive psychology', and even

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[8] Guidelines from the British Association for Counselling & Psychotherapy stipulate 1.5 hours supervision per month for qualified therapists

[9] This is the current situation in the UK's national health service provision, but can also be experienced in the cultural hierarchies of, for example, academic research communities.

'personalisation'. The latter is particularly germane here as one function of this chapter is to indicate the ways in which the conception of personhood found in some of the instances of personalisation described in other chapters in this volume is at odds with that found in the PCA.

The misappropriation of the Person-Centred terminology to describe other practices is common. Freeth asserts that training for mental health professionals prioritises cognitive behavioural and other approaches that "lend themselves more easily to measurement, structured working and evidence-based practice" (2007, p.14). The personalisation of health services is often referred to as 'person-centred', despite not meeting the conditions of the PCA (Freeth 2007, Freeth 2015). As an example, the annual NICE[10] Conference includes an ongoing debate about how to put people at the centre of decision-making and planning in health and social care, but the terminology ('personalisation', 'person-centred', 'patient-led') is used interchangeably (cf Bennett 2014, NICE 2015). Murphy et al (2013) have challenged the ability of contemporary healthcare to be person-centred at all, given the context of managerialism in contemporary social work and Checkland (this volume) has demonstrated the degree to which 'personalised' health provision serves ideological purposes that privilege particular social groups and serves particular managerial imperatives. Misappropriation of the PCA terminology is found also in design communities. Here we see the rise of related terminology, such as: 'Human Centred Design' (HCD), which seeks to tackle 'Grand Challenges' to humanity, including poverty, famine, ecological disasters, and global financial meltdown; 'People-Centred Design', used to describe usability analysis at the Open University (2015), and described as "cost-effective and scalable" at Hugh Graham Creative (2013) and 'Person-Centred Technologies' as a democratic approach to technology development as part a European project (Vanhove 2011).

Chamberlain (2010) explains that HCD is differentiated from user-centred design, as it is holistic; that is, it includes enquiry into the relationship between all stakeholders, the researchers, designers and processes of production and consumption. In addition, it works with what is now, rather than asking participants to make a leap of imagination, and focuses on the creation of products, services and environments which allow participants to live with "dignity, independence and fulfillment" (2010, p.168). However, design practices adhering to the ISO (international standards) for Human Centred Design[11] are not demonstrating a holistic mindset or mode of working, but are rather following guidance on usability, productivity and accessibility; the guidelines are written within the frame of human factors and ergonomics, in which wellbeing is understood to be an outcome of optimal system performance. Similarly the human-centred strand at the 2014 Design Research Society conference primarily focused on ergonomics, although more holistic approaches could be found scattered throughout the rest of the event. In many cases, HCD has replaced UCD (User-Centred Design) as a collection of methods in which co-design, co-production and co-research practices are later analysed by the 'real' researchers – because conclusions still need to be drawn, and results delivered. In addition, user *needs* have to a large extent been augmented if not replaced by users *in need*, and this raises a question about the power relations in philanthropic ventures, in which the co-production of needs and ownership needs to be reflexively managed.

The ImPaCT project was co-ordinated by the European Association of Service providers for People with Disabilities (EASPD); ImPaCT in Europe was a networking project about

[10] the National Institute for Health and Care Excellence

[11] These are communicated by ISO standard 9241-210:2010 Human-Centred Design for Interactive Systems (BSI Standards 2010).

personalised technology, financed by the European Commission Executive Agency for Education, Audiovisual and Culture in the framework of the Lifelong Learning Programme. The project ran between 2009 and 2012, and sought to develop effective Person Centred Technologies for health and social care services in Europe (Vanhove 2011). The project recognised the paradigm shift that had taken place in the way persons with disabilities were seen by society, and took an explicitly democratic approach to its engagement with disabled participants. However, despite attention to ethical issues and the democratic model, and the promotion of Universal Design, 'person centred' and 'personalised' were used as interchangeable terms, and the project did not refer back to the Person Centred Theory or Approach in its methodology or evaluation strategy.

Concluding remarks

The chapter outlined recent calls for reflection on participatory approaches in design research, and described the growing interest in a more holistic model with respect to the 'user'. We provided an introduction to the Person-Centred Approach of Carl Rogers and hope that this will help others reflect on their philosophical working models. In providing an example of a holistic mode of therapeutic practice, we also aimed to demonstrate the need for design researchers to be aware of the spectrum of approaches in the caring professions, so that they may be prepared for conflicting mindsets in interdisciplinary practice, and may be in a position to make informed decisions about the alignment of modes of practice when pursuing holistic participatory projects. We have recognised that aspects of the PCA already exist in some areas of excellent design practice, but that there is a risk of fragmentation and a current lack of a theoretical framework. This might be exacerbated if teams include psychologists working from a deficit model, which would conflict with project aims to engage with people holistically. The PCA offers such a framework for empathy and valuing, providing an underpinning theory, philosophy and a rigorously ethical methodology. It is distinct from current usages of 'HCD', 'UCD', 'patient-centred', 'people-centred', and indeed 'personalisation'. We believe it is only a matter of time before the term 'person-centred' is applied to design and we hope to critically inform its use before it becomes compromised.

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